

**United States Department of Labor
Employees' Compensation Appeals Board**

J.W., Appellant

and

**U.S. POSTAL SERVICE, PROCESSING &
DISTRIBUTION CENTER, Tampa, FL,
Employer**

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**Docket No. 15-1755
Issued: March 23, 2016**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 19, 2015 appellant timely appealed a July 16, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has greater than five percent permanent bilateral upper extremity impairment.

FACTUAL HISTORY

This case has previously been on appeal. The relevant facts follow. On August 20, 2008 appellant, then a 59-year-old mail handler, sustained a traumatic injury in the performance of duty. He was unloading mail from a freight elevator when the overhead door came down and

¹ 5 U.S.C. § 8101 *et seq.*

struck appellant on the left side of his head. OWCP initially accepted the claim for head contusion and cervical strain.² On September 30, 2009 it expanded the acceptance of appellant's claim to include bilateral shoulder adhesive capsulitis (ICD-9 726.0). Appellant retired effective October 31, 2009. He subsequently filed a claim (Form CA-7) for a schedule award.

By decision dated April 9, 2012, OWCP granted a schedule award for five percent permanent impairment of each upper extremity.³ It based the award on a January 12, 2012 impairment rating from appellant's treating physician, Dr. Kenneth P. Botwin, a Board-certified physiatrist with a subspecialty in pain medicine.⁴ The district medical adviser (DMA) reviewed Dr. Botwin's report and similarly found five percent permanent bilateral upper extremity impairment due to shoulder impingement syndrome.⁵

On appeal the Board found that appellant had failed to establish more than five percent permanent impairment of his upper extremities.⁶ The Board's April 10, 2013 decision is incorporated herein by reference.⁷

On May 17, 2013 appellant underwent a right shoulder arthroscopic debridement of the labrum and rotator cuff, subacromial decompression, and distal clavicle resection. Dr. K. Koco Eaton, a Board-certified orthopedic surgeon, performed the right shoulder procedure, which OWCP had authorized. Appellant's postoperative diagnoses included right shoulder impingement, labral tear, partial rotator cuff tear, and acromioclavicular (AC) joint arthritis.

On May 25, 2014 appellant filed a claim for an additional schedule award (Form CA-7).

In a June 10, 2014 report, Dr. Botwin found five percent permanent bilateral upper extremity impairment under Table 15-5, Shoulder Regional Grid, A.M.A., *Guides* 402 (6th ed. 2009). He also rated appellant under Table 17-2, Cervical Spine Regional Grid, A.M.A., *Guides*

² August 20, 2008 cervical spine x-rays revealed spondylosis, with disc space loss greatest at C4-5 and C5-6. Additionally, small ventral and dorsal osteophytes were noted from C4-5 through C6-7. Other than signs of early degenerative changes, there was no evidence of acute fracture or dislocation. An October 8, 2009 cervical magnetic resonance imaging (MRI) scan also revealed cervical spondylosis with central stenosis at C4-5 and C5-6.

³ The award covered a period of 31.2 weeks beginning January 12, 2012.

⁴ Dr. Botwin first examined appellant on September 24, 2009.

⁵ Both Dr. Botwin and the DMA referenced Table 15-5, Shoulder Regional Grid, American Medical Association, *Guides to the Evaluation of Permanent Impairment* 402 (6th ed. 2009).

⁶ Docket No. 12-1595 (issued April 10, 2013).

⁷ Although the Board affirmed the five percent bilateral upper extremity impairment rating, it set aside OWCP's finding with respect to whether appellant was entitled to augmented three-fourths compensation. In an April 26, 2013 corrected award, OWCP recalculated appellant's compensation based on the regular (two-thirds) rate and any applicable cost-of-living increase(s).

564 (6th ed. 2009). Dr. Botwin found “6 [percent] for the cervical spine.”⁸ He noted that appellant had a combined impairment of 16 percent.⁹

The DMA reviewed the case on July 16, 2014 and explained that OWCP does not recognize spinal impairments. Consequently, there was no basis for an award of six percent impairment for the permanent impairment of the cervical spine. The DMA further noted that appellant had previously received an award for five percent permanent bilateral upper extremity impairment due to his shoulders. As such, he was not entitled to an additional award based on Dr. Botwin’s June 10, 2014 five percent permanent bilateral shoulder impairment rating.

By decision dated August 5, 2014, OWCP denied an additional schedule award based on the DMA’s July 16, 2014 report.

On September 9, 2014 appellant requested reconsideration. He submitted a September 5, 2014 impairment rating from Dr. Botwin. At the time, Dr. Botwin diagnosed cervicgia, cervical myofascial pain, cervical neuritis or radiculitis NOS, shoulder joint pain, limb pain, shoulder adhesive capsulitis, bilateral shoulder AC joint syndrome, and rotator cuff syndrome. He explained that appellant sustained permanent injury from his August 20, 2008 accident, which resulted in impairment of the upper extremities. Dr. Botwin further explained that appellant has cervical radiculopathy resulting in bilateral arm impairment, with his right arm more significantly limited. He also noted that appellant had undergone surgery. According to Dr. Botwin, there was impingement on the left side involving the C8 nerve root. There was also evidence of bilateral impingement at C5-6, which affected both upper extremities. Based on appellant’s “radiculopathy,” Dr. Botwin found six percent impairment under Table 17-2, Cervical Spine Regional Grid, A.M.A., *Guides* 564 (6th ed. 2009). He also found seven percent right shoulder impairment under Table 15-5, Shoulder Regional Grid, A.M.A., *Guides* 403 (6th ed. 2009) based on a diagnosis of “S/P [status post] right shoulder surgery.” With respect to appellant’s the left shoulder, Dr. Botwin found five percent impairment under Table 15-5, A.M.A., *Guides* 402 (6th ed. 2009). Lastly, he explained there was a combined 18 percent impairment, which was in addition to appellant’s previous bilateral shoulder rating.

Dr. James W. Dyer, the DMA and a Board-certified orthopedic surgeon, reviewed the record on September 25, 2014, and found that Dr. Botwin’s September 5, 2014 findings did not support an additional schedule award.¹⁰ He explained that Dr. Botwin used Table 17-2, Cervical Spine Regional Grid, A.M.A., *Guides* 564 (6th ed. 2009), rather than for spinal nerve extremity impairment as required under FECA.¹¹ The DMA further noted that Dr. Botwin’s MRI-based

⁸ Appellant’s cervical MRI scans from October 8, 2009, October 26, 2011, and February 4, 2014 all revealed multi-level cervical spondylosis.

⁹ Dr. Botwin’s diagnoses included cervicgia, headache, neuralgia and neuritis, muscle spasm, limb pain, shoulder joint pain, bilateral shoulder AC joint syndrome, and cervical neuritis or radiculitis -- not otherwise specified (NOS).

¹⁰ Dr. Dyer previously reviewed the record in conjunction with OWCP’s April 9, 2012 schedule award.

¹¹ As discussed *infra*, FECA does not provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole. Where a spinal condition affects the upper and/or lower extremities, a schedule award is permissible. The FECA-approved methodology for rating cervical-related upper extremity impairment is set forth in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009).

finding of cervical radiculopathy was not supported and/or confirmed by upper extremity electrodiagnostic studies. Consequently, he found no (zero) additional impairment of the upper extremities.

In an October 16, 2014 decision, OWCP reviewed the merits of appellant's latest schedule award claim, but denied modification based on the DMA's September 25, 2014 report.

During an October 21, 2014 telephone conversation with OWCP, appellant noted that no one addressed the fact that he had undergone surgery. In a November 10, 2014 letter to OWCP, he again commented about his May 2013 right shoulder surgery, which reportedly had not eliminated his problems. Appellant also noted that Dr. Botwin was unfamiliar with *The Guides Newsletter*.

On November 13, 2014 appellant formally requested reconsideration. He submitted a November 7, 2014 report from Dr. Botwin. In an effort to clarify his September 5, 2014 report, Dr. Botwin explained that, despite right shoulder surgery and postprocedure injections, appellant's pain persisted. He attributed appellant's symptoms to concomitant cervical radiculopathy, which finding was reportedly based upon physical examination. Dr. Botwin indicated that appellant's impairment involved both the arm and shoulder. He further noted that the shoulder injuries had been rated seven percent on the right and five percent on the left under Table 15-5, Shoulder Regional Grid, A.M.A., *Guides* 402-03 (6th ed. 2009). As for the cervical spine condition, this was rated at six percent under Table 17-2, Cervical Spine Regional Grid, A.M.A., *Guides* 564 (6th ed. 2009).¹² Dr. Botwin noted that the cervical spine impairment rating was based on medically documented physical examination findings of a cervical disc injury. He also noted that the cervical rating was in addition to the previous rating given for the shoulders.

Since issuing its October 16, 2014 merit decision, OWCP received the results of a November 25, 2014 bilateral upper extremity electromyography and nerve conduction study (EMG/NCV). Dr. Botwin described the NCV results as normal. However, he noted that the EMG results showed increased insertional activity in the bilateral cervical paraspinal and polyphasic motor units at C5, which could represent chronic bilateral C5 myotomal radiculopathy. Dr. Botwin also reported there was no large fiber-type neuropathy or plexopathy.

Additionally, OWCP received the results of a December 2, 2014 bilateral upper extremity small fiber/pain fiber nerve conduction study. Dr. Botwin indicated that the results were consistent with nerve/disc irritation at the right T1 level. He also noted there was involvement of the cervical facets at both levels from C2 - T1, bilaterally.

In a January 30, 2015 decision, OWCP denied modification. The senior claims examiner found that Dr. Botwin's November 7, 2014 report was essentially the same as his September 5, 2014 report, which the DMA previously found insufficient. She reiterated that it was crucial to have electrodiagnostic studies of the upper extremities to confirm radiculopathy, which were purportedly absent.¹³ The senior claims examiner further noted that Dr. Botwin admittedly had

¹² Dr. Botwin acknowledged that he was unfamiliar with *The Guides Newsletter*.

¹³ The senior claims examiner found there were "no results of electrodiagnostic testing necessary to arrive at [Dr. Botwin's six percent cervical spine impairment] rating."

not based his impairment rating on *The Guides Newsletter* for rating spinal nerve extremity impairment.

On February 20, 2015 appellant filed a new request for reconsideration. He submitted a February 18, 2015 impairment rating from Dr. Botwin who found four percent bilateral upper extremity impairment. Dr. Botwin noted that appellant had both motor and sensory deficits in the C5 and C6 nerve root distributions, bilaterally. Electrodiagnostic studies reportedly confirmed the levels of involvement. Applying *The Guides Newsletter*, Dr. Botwin found that under Proposed Table 1 (Spinal Nerve Impairment: Upper Extremity Impairments) appellant had a mild sensory deficit at C5 and C6, bilaterally.¹⁴ He further noted that this impairment was in addition to the previous rating for appellant's bilateral shoulder condition.

OWCP also received Dr. Botwin's February 20, 2015 follow-up treatment notes where he indicated, *inter alia*, that appellant had pain fiber NCV results consistent with bilateral cervical spinal nerve root impairment. He reiterated that appellant had five percent (whole person) impairment based on sensory deficits involving the C5 and C6 nerve roots, bilaterally. Again, Dr. Botwin noted that appellant's sensory impairment was in addition to his prior rating for the bilateral shoulder condition.

By decision dated April 6, 2015, OWCP denied modification of its January 30, 2015 decision. The senior claims examiner noted that although Dr. Botwin claimed that his February 18, 2015 impairment rating was based on electrodiagnostic studies, the report only listed an October 14, 2009 EMG/NCV that Dr. Botwin characterized as normal.¹⁵ Consequently, OWCP found that Dr. Botwin's February 18, 2015 report was of diminished probative value.

On April 15, 2015 appellant requested reconsideration. He had recently undergone additional testing, which included left shoulder and cervical MRI scans, as well as a bilateral upper extremity EMG/NCV.

An April 7, 2015 left shoulder MRI scan revealed moderate AC joint osteoarthritis and mild glenohumeral joint osteoarthritis, which had progressed slightly when compared to appellant's May 30, 2012 scan. The latest study also revealed mild supraspinatus tendinopathy, which was new. Additionally, there was no evidence of a rotator cuff tear.

Appellant's April 29, 2015 cervical MRI scan revealed a congenitally small cervical canal, as well as multilevel congenital and acquired partial central canal stenosis; most pronounced at C4-5 and C5-6. There was also evidence of high-grade bilateral neuroforaminal compromise at C7-T1. Appellant's latest cervical MRI scan reportedly showed no significant changes when compared to his February 4, 2014 study.¹⁶

¹⁴ Citing Table 15-11, A.M.A., *Guides* 420 (6th ed. 2009), Dr. Botwin noted that appellant's combined eight percent upper extremity impairment represented five percent whole person impairment.

¹⁵ In his February 18 and 20, 2015 reports, Dr. Botwin did not include the diagnostic studies from November 25 and December 2, 2014.

¹⁶ Dr. Robert A. Zamore, a Board-certified diagnostic radiologist with a subspecialty in neuroradiology, interpreted appellant's April 29, 2015 cervical MRI scan.

An April 21, 2015 upper extremity EMG/NCV revealed normal NCV results, but the EMG was interpreted as abnormal. Dr. Botwin reported increased insertional activity in the bilateral cervical paraspinal and denervation in the bilateral C5-6 myotomes, consistent with bilateral myotomal radiculopathy. He also noted that the latest results showed a progression from appellant's November 25, 2014 study. There was no evidence of large fiber-type neuropathy, plexopathy, or myopathy.

Dr. Botwin included the results of appellant's recent studies in his April 30 and May 5, 2015 follow-up examination reports. In the latter report, he diagnosed neck sprain and strain, cervicalgia, cervical neuritis or radiculitis NOS, limb pain, bilateral shoulder AC joint syndrome, adhesive capsulitis of shoulder, rotator cuff syndrome, and shoulder joint pain. Dr. Botwin explained that the latest MRI scan findings and the April 21, 2015 EMG results supported his February 18, 2015 impairment rating, which he attributed to appellant's August 20, 2008 injury.

By decision dated July 16, 2015, OWCP reviewed the merits of the schedule award claim, but denied modification. The senior claims examiner reviewed Dr. Botwin's May 5, 2015 report and noted that he had diagnosed several conditions OWCP had not accepted, including "cervical radiculitis." He further noted that cervical strain, which was an accepted condition, "usually resolves in six to eight weeks." After reviewing the results of appellant's latest cervical MRI scan and EMG/NCV, the senior claims examiner determined that the conditions responsible for appellant's increased impairment were "congenital in nature" and unrelated to his employment injury.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.¹⁷ FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.¹⁸ Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).¹⁹

Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.²⁰ However, a schedule award is

¹⁷ For complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

¹⁸ 20 C.F.R. § 10.404.

¹⁹ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (February 2013); see also Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

²⁰ 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a); see Jay K. Tomokiyo, 51 ECAB 361, 367 (2000).

permissible where the spinal condition affects the upper and/or lower extremities.²¹ The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment.²² It was designed for particular jurisdictions, such as FECA, which mandate ratings for extremities and preclude ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.²³

When determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.²⁴ Impairment ratings for schedule awards include those conditions accepted by OWCP as job related, and any preexisting permanent impairment of the same member or function.²⁵ If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate.²⁶ There are no provisions for apportionment under FECA.²⁷ But when the prior impairment is due to a previous work-related injury and a schedule award has been granted for such prior impairment, the percentage already paid is subtracted from the total percentage of impairment.²⁸

If a claimant sustains increased impairment at a later date which is due to work-related factors, an additional award will be payable if supported by the medical evidence.²⁹ In this situation, the original award is undisturbed and the new award has its own date of maximum medical improvement (MMI), percent of impairment, and period of award.³⁰ This may occur if the claimant sustains additional impairment due to the original work factors with no intervening or additional exposure to those same work factors.³¹

²¹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a(3) (February 2013).

²² The methodology and applicable tables were published in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009).

²³ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

²⁴ *Carol A. Smart*, 57 ECAB 340, 343 (2006); *Michael C. Milner*, 53 ECAB 446, 450 (2002).

²⁵ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.5d (February 2013).

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.* at Chapter 2.808.7a(1) (February 2013); 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

²⁹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.9b (February 2013).

³⁰ *Id.*

³¹ *Id.*

ANALYSIS

In April 2012, appellant received a schedule award for five percent permanent impairment of each upper extremity. The rating was based on a diagnosis of bilateral shoulder impingement syndrome under Table 15-5, A.M.A., *Guides* 402 (6th ed. 2009). In May 2013, appellant underwent OWCP-approved right shoulder arthroscopic surgery, which included distal clavicle resection. Almost one year postsurgery, he filed a claim (Form CA-7) for an additional schedule award. In support of this latest claim, appellant submitted a June 10, 2014 report from Dr. Botwin who found an additional “six [percent] for the cervical spine” under Table 17-2, Cervical Spine Regional Grid, A.M.A., *Guides* 564 (6th ed. 2009). Dr. Botwin also reiterated his prior rating of five percent bilateral shoulder impairment under Table 15-5, A.M.A., *Guides* 402 (6th ed. 2009).

Based on the opinion of its DMA, OWCP declined an additional schedule award by decision dated August 5, 2014. Dr. Botwin’s June 10, 2014 rating did not demonstrate an increase with respect to appellant’s bilateral shoulder impairment. As to the six percent rating for appellant’s cervical spine, OWCP advised that FECA does not provide for the payment of a schedule award for the permanent loss of use of the back/spine.³² Consequently, it denied an additional schedule award by decision dated August 5, 2014.

Appellant requested reconsideration and submitted a September 5, 2014 rating from Dr. Botwin who noted, *inter alia*, seven percent right upper extremity impairment due to “[status post] right shoulder surgery.” Dr. Botwin referenced Table 15-5, Shoulder Regional Grid, A.M.A., *Guides* 403 (6th ed. 2009), but when the DMA reviewed Dr. Botwin’s September 5, 2014 report, he did not reference the right shoulder postsurgery seven percent impairment. The DMA’s September 25, 2014 report focused entirely on Dr. Botwin’s finding of six percent cervical spine impairment.

As noted, appellant’s authorized May 17, 2013 right shoulder arthroscopic procedure included a distal clavicle resection. Under Table 15-5, A.M.A., *Guides* 403 (6th ed. 2009), an AC joint injury or disease that is “s/p Distal clavicle resection” represents a class 1 upper extremity impairment with a range of 8 to 12 percent. The default (C) impairment rating is 10 percent. Prior to his surgery appellant had received a five percent rating for right shoulder impingement syndrome pursuant to Table 15-5, A.M.A., *Guides* 402 (6th ed. 2009). Because the DMA failed to consider whether appellant’s May 2013 right shoulder surgery resulted in an increased impairment as noted by Dr. Botwin, the case shall be remanded for further consideration.³³

In its latest merit decision, OWCP denied modification because appellant’s increased impairment was purportedly due to a congenital condition of the cervical spine. It based this finding on a narrow reading of appellant’s April 29, 2015 cervical MRI scan, the results of which Dr. Botwin included in his May 5, 2015 report.

³² 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

³³ Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case. *Richard F. Williams*, 55 ECAB 343, 346 (2004).

Dr. Zamore, the radiologist who reviewed the latest cervical MRI scan, noted that appellant's cervical canal was "congenitally small." He also noted "[c]ongenital and acquired partial central canal stenosis" at multiple levels, but most pronounced at C4-5 and C5-6. The Board notes that appellant's three prior cervical MRI scans dating back to October 2009 made no mention of a congenitally small cervical canal. In fact, the first reference to central stenosis at C4-5 and C5-6 noted that the condition was the result of a combination of changes, including disc degeneration with osteophyte formations, disc bulges, and hypertrophy of ligamentum flavum. Despite Dr. Botwin's assertion that appellant's upper extremity impairment was due to his August 20, 2008 employment injury, the senior claims examiner dismissed his May 5, 2015 report as appellant's increased impairment was "congenital in nature," and unrelated to his employment injury. This action was improper as it is the function of the claims examiner to decide the facts in the case.³⁴ Moreover, the claims examiner "must" utilize the DMA when adjudicating a schedule award claim and calculation of the percentage of impairment is required in order to establish the schedule award.³⁵

Appellant's date-of-injury cervical x-rays revealed early degenerative changes at C4-5 through C6-7. To date, OWCP has only accepted cervical strain as work related. However, impairment ratings for schedule awards include those conditions accepted by OWCP as work related, and any preexisting impairment of the same member or function.³⁶ Whether appellant's upper extremity impairment is partly due to a congenitally small cervical canal and/or a preexisting degenerative condition does not preclude the condition's inclusion in a schedule award. Accordingly, the Board finds that the case is not in posture for decision.

On remand, OWCP shall further review the evidence consistent with this decision and if appropriate, refer the case record to an OWCP medical adviser for review. After OWCP has developed the medical record consistent with the above-noted directive, it shall issue a *de novo* decision regarding appellant's entitlement to an additional schedule award.

CONCLUSION

The case is not in posture for decision.

³⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8 (September 2010); see e.g., *Barbara Bush*, 38 ECAB 710 (1987).

³⁵ See *id.* at Chapter 2.810.8d(1).

³⁶ *Id.* at Chapter 2.808.5d (February 2013).

ORDER

IT IS HEREBY ORDERED THAT the July 16, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: March 23, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board